DMR ELECTRONIC DEATH REPORTING FORM (TO BE COMPLETED WITHIN 24 HOURS)

(1) INDIVIDUAL Last Name: ____ _____ (2) First Name: _ _____ (3) SS#: ____-____-____

(4) DATE OF BIRTH: / / (5) Age: (12) Region: (check one) NE☐ CW☐ SE☐ Metro☐

(6) Address Line 1: ____ _____ (13) Area Office/Facility: Select:Select (Dictionary #1)

(7) Address Line 2: __ _____ (14) Class Status: (check all that apply) Ricci☐ Rolland☐ _Boulet☐ Brewster ☐

(8) City : __ _____ (9) State: __ __ (10) Zip Code: __ __ (15) Guardian Status: (check appropriate status) Full Guardian☐ No Guardian ☐

(11) Phone: ___ _____ (16) Level of MR: (check appropriate level) Mild ☐ Moderate☐ Severe ☐ Profound ☐

(17) Down Syndrome: Yes ☐ No☐

(18) Individual's Service Coordinator: _ _____ (19) Service Information: ___ _____

(20) PCP Last Name: _____ (21) First Name: _____ (22) PCP Phone No.: _____

(23) DATE OF DEATH: / / (24) TIME OF DEATH: ☐ A.M. ☐ P.M.

(25) TYPE OF LOCATION OF DEATH: Select One Acute Care Hospital ☐ Nursing Home ☐ During Transportation to/from DMR Funded Program ☐ DMR Residence ☐ DMR Facility ☐ Family Home ☐ Adult Foster Care ☐ DMR Funded Employment/Community-based Day Habilitation Program ☐ Other ☐

(26) NAME OF ACTUAL LOCATION OF DEATH (if any):

(27) STREET ADDRESS Line 1: _ _____

(28) STREET ADDRESS Line 2: _ _____

(29) CITY: _ _____(30) STATE: _ ___ (31) ZIP: ___ (32) TELEPHONE: ( ) -

(33) REPORTER's LAST NAME: _____ (34) First Name: _ _____ (35) TITLE: _ _____

(36) REPORTER'S AREA OFFICE/FACILITY:_Select_Select_____ (37) REPORTER'S PHONE NO..: _____ (Dictionary #1)

(38) DATE OF REPORT: / /

(39) PRESUMED DIAGNOSIS AT TIME OF DEATH: _____SelectSelect_____ (DICTIONARY #2)

(40) IF "OTHER" PRESUMED DIAGNOSIS, PLEASE DESCRIBE ____ _____

(41) FACTS AND CIRCUMSTANCES OF DEATH: ___ _____

_____

(42) Did the person have a Level II or Level III Behavior Modification Plan? Yes ☐ No ☐ (44) Was a DR in place? YES ☐ NO ☐ UNK ☐

(43) Was the person being Restrained or in Time Out at or just prior to death? Yes ☐ No ☐ (45) At time of Death, Receiving Hospice? YES ☐ NO ☐ UNK☐

(46) ***MORTALITY REVIEW*** - Is a Mortality Review required? YES ☐ NO ☐ NOT REQUIRED BUT REQUESTED ☐

(47) IF REQUESTED, REASON FOR THE REQUEST: _ _____

_____

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INDIVIDUAL LAST NAME: _____ FIRST NAME: _____

NOTIFICATIONS:

(48) Was the Senior Investigator (or Regional on-call person, if after hours) notified by phone immediately? Yes ☐ No ☐
(49) Was DPPC notified immediately by phone (18-59 yrs. old)? Yes ☐ No ☐ (50) Date: / /
(51) Time: ☐ A.M. ☐ P.M.
(52) WAS THE DEATH UNEXPECTED AND/OR WERE THE CIRCUMSTANCES SUSPICIOUS? Yes ☐ No ☐ Unknown ☐
(53) WAS THE DEATH UNDER SUSPICIOUS CIRCUMSTANCES: Yes ☐ No ☐ Unknown ☐
(54) WAS THERE ANY INDICATION OF VIOLENCE (INCLUDING SEXUAL ABUSE)? Yes ☐ No ☐ Unknown ☐
(55) WERE THE STATE/LOCAL POLICE NOTIFIED IMMEDIATELY? Yes ☐ No ☐ IF ANSWER TO (54) IS "YES", MUST NOTIFY
(56) WAS THE MEDICAL EXAMINER'S OFFICE NOTIFIED? Yes ☐ No ☐ IF ANSWER TO (54) IS "YES", MUST NOTIFY
(57) IF (56) IS YES, DID IT TAKE JURISDICTION? Yes ☐ No ☐
(58) IF THE INDIVIDUAL WAS OVER 60 YEARS OLD AND IF THERE ARE INDICATIONS OF VIOLENCE, WAS EOEA NOTIFIED IMMEDIATELY BY PHONE?)? Yes ☐ No ☐ (59) Date: / /
(60) Time: ☐ A.M. ☐ P.M.

THIS FORM MUST BE COMPLETED BY THE DMR AREA OFFICE OR FACILITY AND MUST BE SENT WITHIN 24 HOURS TO BOTH DMR CENTRAL OFFICE OPERATIONS, REGIONAL DIRECTOR (FOR COMMUNITY INDIVIDUALS) AND ASSISTANT COMMISSIONER FOR FACILITIES (FOR FACILITY INDIVIDUALS).

DMR CENTRAL OFFICE OPERATIONS REVIEW

(61) IS THE DEATH REPORT ACCEPTED: Yes ☐ No ☐

(62) IF NOT, WHY NOT? _____

_____

(63) DEATH CERTIFICATE CAUSE OF DEATH (IMMEDIATE):

_____

(64) DEATH CERTIFICATE CAUSE OF DEATH (UNDERLYING):

_____

(65) DEATH CERTIFICATE MANNER OF DEATH:

_____

(66) CLINICAL MORTALITY REVIEW RECEIVED? Yes ☐ No ☐

(67) FINAL CAUSE OF DEATH (PRIMARY): Select Select_____
DICTIONARY #2

(68) UNDERLYING CAUSE OF DEATH (SECONDARY): Select_____
DICTIONARY #3

(69) MANNER OF DEATH: _____

(70) WAS THE CLINICAL MORTALITY REVIEW CLOSED AT THE REGIONAL/FACILITY LEVEL? Yes ☐ No ☐